NEVADA RURAL HEALTH TRANSFORMATION GRANT APPLICATION

Opportunity Number: CMS-RHT-26-001

November 5, 2025

Submitted by:
Nevada Health Authority

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I. Project narrative: Introduction

Rural Nevadans face significant challenges when trying to access health care. The state's vast and remote geography, mountainous and desert terrains, low population density, and limited number of rural healthcare providers contribute to these challenges.[i] Because of these conditions, many rural residents live in what some refer to as healthcare deserts—meaning they lack adequate access to critical healthcare services.[ii]

Thanks to the new federal grant opportunity made available through the Rural Health Transformation (RHT) Program, Nevada has an unprecedented opportunity to transform its rural healthcare system into one that is more accessible, innovative, and sustainable. As outlined in the state's application, Nevada intends to deploy a coordinated and targeted strategic plan that will be led by the Nevada Health Authority in collaboration with state and local partners and a steering committee with broad representation from rural hospitals and providers, healthcare experts, community stakeholders, rural residents, and state, tribal, and local health officials.

II. Rural health needs and target population

Nevada is the 7th largest state in the country, encompassing 110,577 square miles with two major deserts and the largest number of mountain ranges in the country.[iii] According to the U.S. Health Resources and Services Administration (HRSA), only three Nevada counties are considered urban with three of the remaining counties labeled as rural and 11 labeled as frontier (i.e., remote areas of wilderness).[iv]

Although rural and frontier counties make up about 90 percent of the state's land mass (at 95,500 square miles), only 10 percent of the state's population live in these areas.[v]

See Attachment labeled Rural Demographics for a graphic representation of the state's rural land mass and Rural-Urban Commuting Areas.

A. The Target Population

The target population consists of about 294,000 residents who live in the 14 counties designated as rural and frontier by HRSA.[vi] These counties are also home to 24 of the state's 28 federally recognized Tribal nations, bands, and councils.[vii] Twenty-seven percent of the state's prison population are in rural and frontier counties.[viii]

Nevada hospitals and clinics operating in rural and frontier counties will be eligible to benefit from this new federal grant opportunity. Academic institutions and other state, local or private entities, non-rural providers and vendors that collaborate with the state and rural health delivery systems to expand access to care and improve health outcomes in rural Nevada may also be eligible to benefit from these grant funds – with the requirement that these funds primarily benefit the rural healthcare system and rural residents.

Additionally, all RHT funds must be used for, and stay within, the state of Nevada. The terms and conditions of federal awards will flow down to subawards and subrecipients per relevant cost limitations, and subawards or contracts will be consistent with the requirements specified by CMS and the state's approved application.

B. Rural Health Needs

Demographics for Nevada's rural population are as follows in the table below:

Table 1: Rural Demographics

Statistics	Demographics
11.5%	Live in poverty
16%	Rural children live in poverty

26%	Enrolled in Medicaid
25%	Enrolled in Medicare
$40,694 to $92,388	Median household income (2022)
9%	Uninsured rate
15%	% of state's total veteran population in rural
85%	Graduated from high school
18.7%	Hold a bachelor's degree or higher
37%	Receive Social Security and retirement
10%	Receive unemployment benefits
74%	White/Caucasian residents
18%	Hispanic residents
4%	Native American residents
2%	Asian American and African American
58%	Ages 18-64 years old
22%	Over age 64
18%	Under the age of 18
27%	% of state prison population

Nevada Rural & Frontier Health Data Book, 2025.

There are 14 rural and frontier hospitals in Nevada with 20 provider-based rural health clinics (RHCs). Of these 14 hospitals, six are not-for-profit publicly owned hospitals, four are not-for-profit privately owned hospitals, three are for-profit privately-owned hospitals and one is a not-for-profit non-governmental hospital. The state also has 11 federally qualified health centers (FQHCs) and 3 certified community behavioral health centers (CCBHCs) that operate in rural and frontier counties. For rural Tribal communities, Nevada also has 13 Tribal and Indian Health Service (IHS) clinics and health centers.[ix]

Even with this mix of healthcare clinics and facilities, significant gaps in the continuum of care remain in rural and frontier counties. Rural residents lack local opioid treatment programs, sole community hospitals (SCHs), rural referral centers, Medicare-dependent hospitals, low volume hospitals, and rural emergency hospitals (REHs).

On average, rural residents must drive approximately 56 miles to access the nearest hospital or 109 miles to access the nearest tertiary care hospital for specialized treatment.[x] These figures highlight the spatial isolation and vast geographic distances

that characterize most rural communities in Nevada.

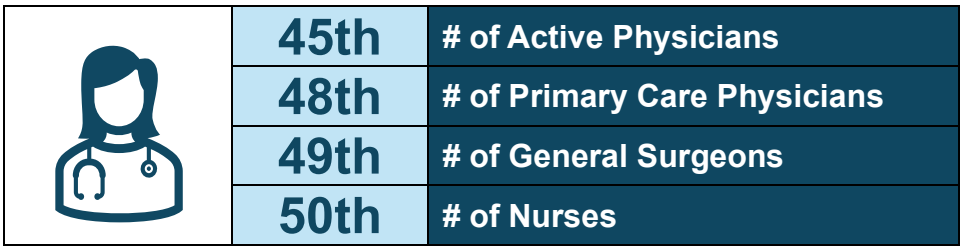
Additionally, over the last two decades, Nevada has experienced health facility closures across the state—resulting in critical gaps in care and greater inconvenience for rural Nevadans who relied on these health facilities. These closures included two low-volume hospitals and two FQHCs that served rural communities. One of these facilities was located on Tribal land, further compounding the historic health challenges for Tribal communities in that region of the state.[xi]

These closures emphasize the vulnerability of the essential healthcare infrastructure in underserved regions of Nevada and highlight the urgent need for targeted investments to preserve and strengthen rural and Tribal health systems. Furthermore, six of the private CAHs currently serving rural residents are recipients of supplemental payments under the state's private hospital provider tax.[xii] Due to changes to these tax programs under H.R. 1 (2025), these six CAHs will experience revenue reductions once these changes begin to go into effect over the next three-to-five years.

Every county in Nevada has one or more federal Health Professional Shortage Areas (HPSAs) designations, with 75 HPSAs for primary care, behavioral health, and dental services; and of these, 38 are in rural or partially rural counties.[xiii] Approximately 250,000 people (about 8% of the state's population) live in rural communities with little to no access to primary care.[xiv] And it is not just a rural issue; more than two-thirds of Nevadans (about 2.3 million people) live in areas that do not have an adequate number of primary care providers (Primary Care HPSA). The state also consistently ranks near the bottom nationally in the availability and number of physicians and nursing professionals as

illustrated in Figure 1 below.[xv]

Figure 1: Nevada's National Rankings for Healthcare Provider Access



A deeper analysis of these statistics reveals substantial gaps in key clinical roles across rural and underserved areas. For example, in urban areas of the state, there are on average 101.2 primary care physicians per 100,000 residents, whereas in rural areas, there are only 60 primary care physicians on average per 100,000 residents.[xvi] The rural nursing care disparity is even more acute, where the ratio falls to only 6.03 nurses per 1,000 people.[xvii]

Given these figures, it is no surprise that the state has only met 44 percent of its healthcare provider capacity needs.[xviii] According to HRSA, Nevada must attract 156 more providers, including 78 primary care providers, 52 behavioral health professionals, and 26 dental practitioners, to meet the basic needs of residents.[xix] Additionally, to meet national per capita employment rates for nurses, Nevada would need to add 4,913 RNs, 717 APRNs, 3,154 LPNs, and 5,372 CNAs.[xx]

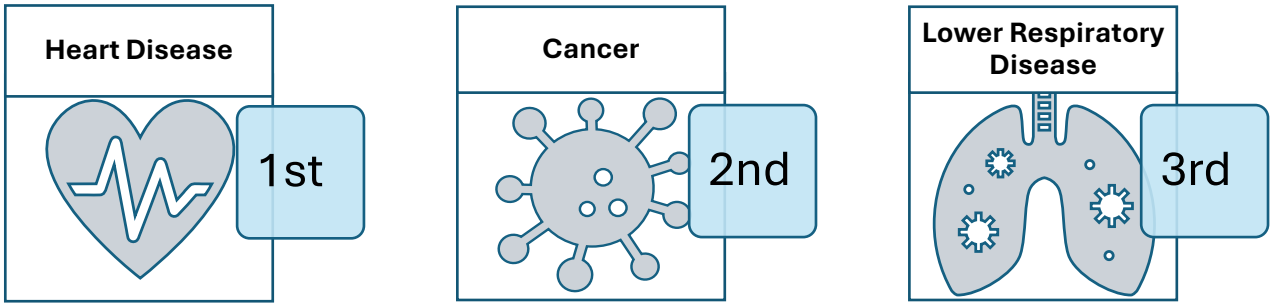
Table 2: Nevada's Shortages & Provider Capacity Needs

	HPSA (Shortages)	Rural-Only HPSAs (Shortages)	#Providers Needed	% of Needs Met[3]
Primary Care	32	18	78	43.7 %
Behavioral Health	27	13	52	41.9 %
Dental Services	16	7	26	39.4 %
Total/Statewide	**75**	**38**	**156**	**44% (avg)**

The impacts of these healthcare workforce challenges are evident in Nevada's health rankings as compared to other states. Nevada continually ranks in the bottom ten,

nationally, in health quality, outcomes, and access, with alarming rates of chronic conditions, maternal and infant morbidity and mortality, and mental health outcomes.[xxi] With respect to specific health statistics in rural Nevada, the leading causes of death among rural Nevadans are heart disease, cancer, and chronic lower respiratory disease (CLRD), with age-adjusted CLRD rates being higher in rural regions than urban.

Figure 2: Leading Causes of Death in Rural Nevada



The following statistics provide a snapshot of other population health indicators:

- The prevalence of **adult diabetes** increased over the past decade with rates slightly higher in rural versus urban counties.
- Larger percent of adults in rural counties **smoke** as compared to urban counties.
- Over the past decade, the prevalence of **adult obesity** increased in most counties of Nevada with the highest rates in rural counties.
- About 74% of screened rural and frontier children had tooth decay experience versus 65% of students screened in Urban areas.
- Since 2014 several Nevada Rural Counties (Esmeralda County, Lander County, Pershing County, and White Pine County) are **dental care deserts** for Medicaid recipients and those with low to no dental insurance.

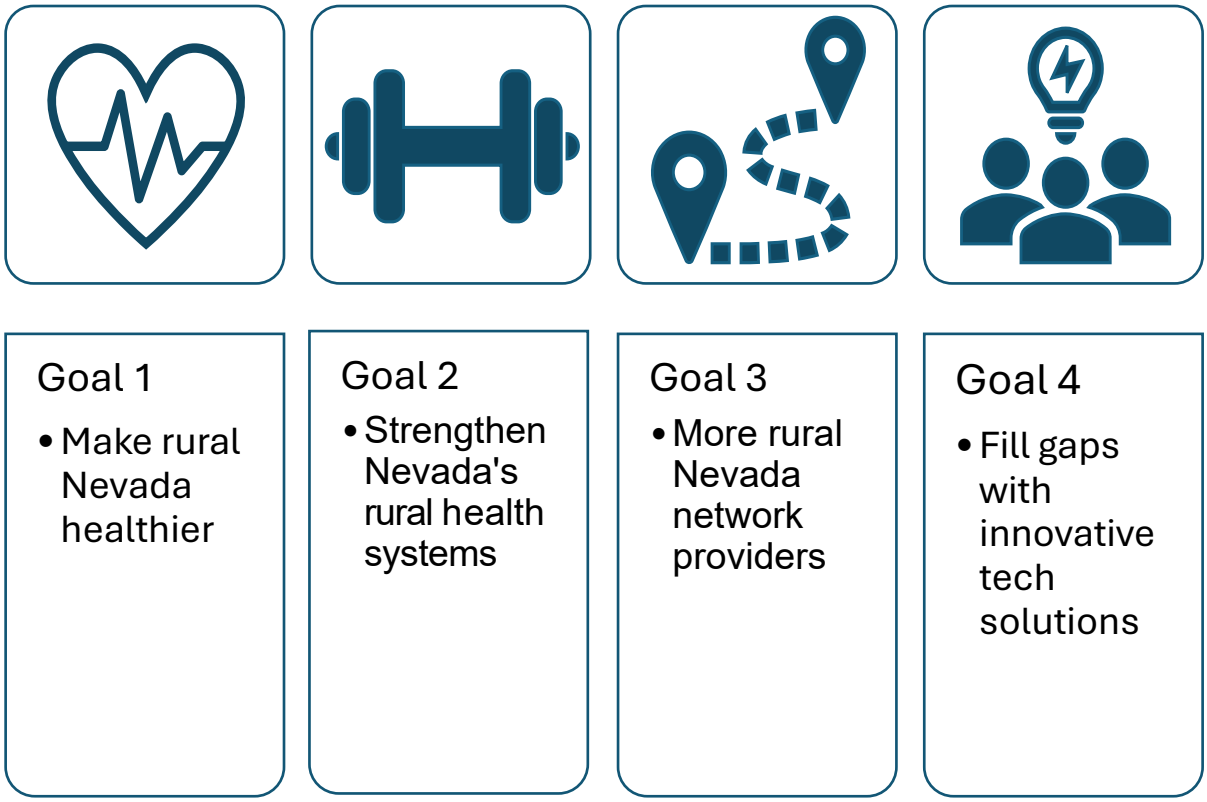
- Certain rural counties have the highest rates of **alcohol consumption and smoking during pregnancy** and higher rates of premature birth.
- State data on maternal behaviors and birth outcomes indicate substantial barriers faced by women seeking prenatal care in rural areas that translate into **low-birth-weight babies and premature births.**
- Rural counties in total have higher rates of **childhood disabilities** than urban counties, specifically developmental delays, speech/language and hearing impairments and other impairment disabilities.
- Certain rural counties have the highest **all-cause mortality rates** in the state.
- Northern rural Nevadans (22.7 percent) and southern rural Nevadans (24.3 percent) have a higher percentage of **mental illness** as compared to the statewide and national averages of 20.2 percent.
- Rural counties show higher rates among high school students of **smoking, vaping, binge drinking, and prescription drug use** as compared to the state average.
- Age-adjusted **suicide rates** in Nevada are higher in rural regions than in urban areas.

III. Rural health transformation plan: goals and strategies

As outlined by Governor Joe Lombardo in his **3-Year Strategic Plan & Policy Matrix**, improving the health and wellness of Nevadans is a core state priority. The federal goals for the RHT program align with Governor Lombardo's key goals for improving health and wellness by attracting talent to address healthcare workforce shortages, improving access to primary care and public health, reducing the dependency on social services, addressing mental illness, and ensuring veterans have access to appropriate care.

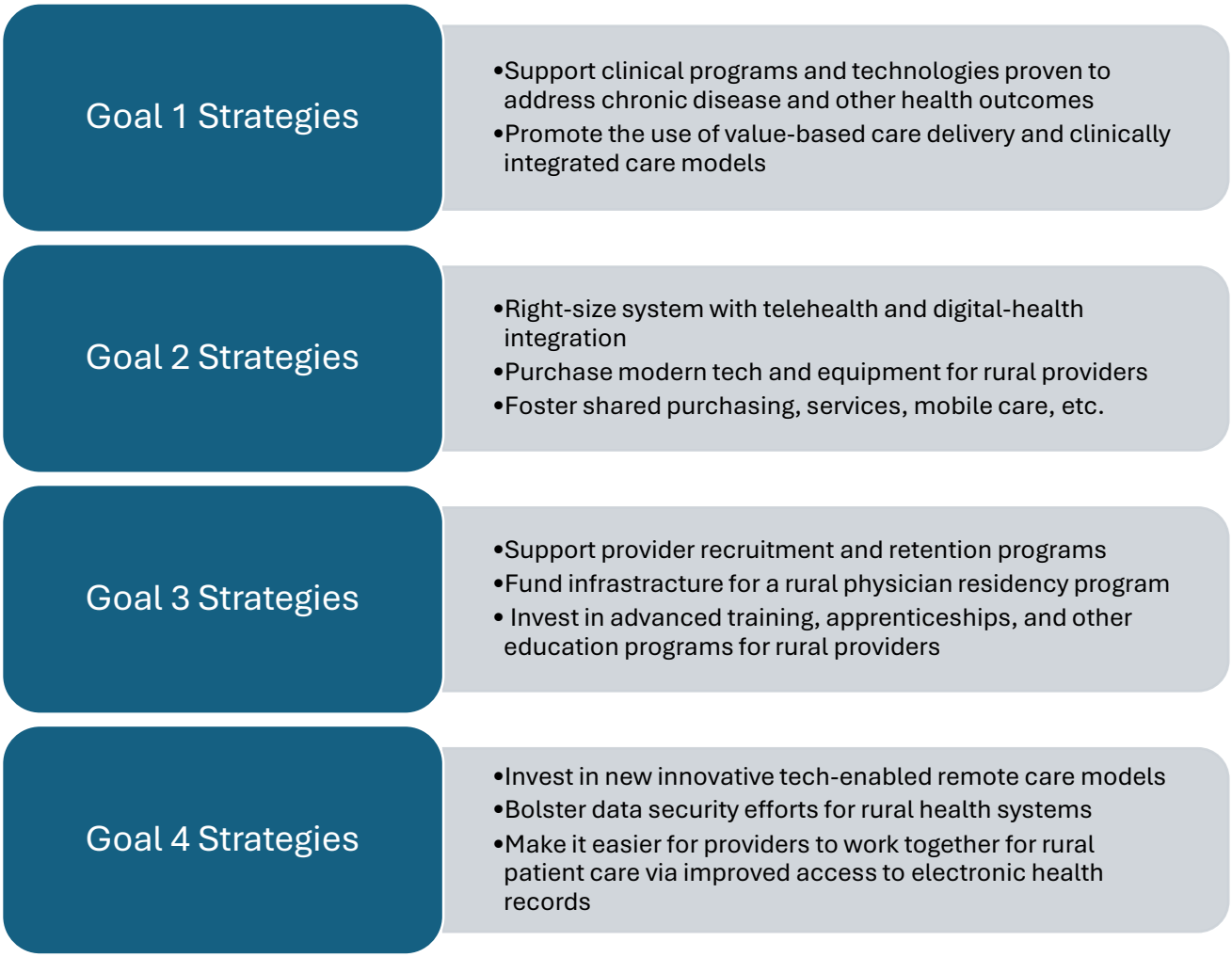
Building off the Governor's plan, the Nevada Health Authority intends to focus on four goals and strategies: (1) making rural Nevada Healthy again; (2) strengthening rural health systems; (3) creating a robust network of health providers in rural Nevada; and (4) filling the "unfillable" gaps with innovative tech solutions.

Figure 3: Nevada's Four Core Goals & Specific Strategies



Nevada intends to deploy the strategies outlined in Figure 4 to meet these goals and align with the federal goals for the RHT Program.

Figure 4: Nevada's Strategies for Each Goal



To make rural Nevada Healthy again, the state must **improve access** to quality care through innovative rural delivery systems. This means Nevada must address the historic service gaps in the rural healthcare continuum through scalable, sustainable, and flexible virtual care solutions and more modern technology, health data sharing capabilities, and telehealth infrastructures to support sustainable hybrid systems of care.

To **improve health outcomes**, Nevada will deploy **$30 million** in year one for sustainable strategies to promote new innovative hybrid (remote and in-person) care

delivery models and multi-payer value-based payment structures. An applicant must show that the model it will employ is **data-driven**, meaning there is evidence that it is an effective method for achieving efficiencies and improving health outcomes in at least one of the areas identified by the state as a core health focus (i.e., chronic disease, behavioral health, and maternal/infant morbidity and mortality in rural areas of Nevada).

Examples of such efforts consist of projects that create new access points to care in rural parts of the state, such as remote care options, virtual specialty mentorship programs, tech-enabled hybrid care models, community paramedicine, community health workers or other care coordination and service extenders, and mobile health units. The state is also interested in funding new consumer-facing health technology, including smart phone apps and other AI chat tools, that provide digital health prevention and chronic condition management tools for rural patients and their providers.

Nevada intends to invest **$40 million** in year one to stabilize and right-size rural hospitals and clinics by funding projects that **support capital and infrastructure** needs and modernization in addition to service-line optimization. Examples include the purchase of medical supplies and equipment (such as imaging equipment), lab and testing technologies, telemedicine infrastructure, and remote monitoring technologies. The state also seeks to incentivize local health systems to participate in regional purchasing arrangements, service/technology sharing programs, and regional rural medical transport supports such ambulances, regionally shared emergency airlift transport, and non-emergency medical transportation vehicles or ride-sharing programs.

For **workforce** initiatives, Nevada intends to invest **$80 million** into new programs to address the state's provider shortages for rural Nevadans. Nevada's rural health workforce strategy is designed to create a sustainable pipeline of qualified clinicians, address persistent vacancy rates, and ensure long-term retention in medically underserved regions. The state will prioritize workforce development as the foundation of its RHTP strategy, addressing immediate gaps with incentive programs to attract providers, while building long-term capacity with tuition, training, and residency programs; coupled with rural-living retention requirements for RHT recipients

Nevada also intends to infuse about **$30 million** in year one on **the use of technology** to address the challenges facing rural Nevadans with promoting digital-health advancement and cybersecurity in the state's rural healthcare system. Examples include investments in technology upgrades to support data sharing, cybersecurity reinforcement, and other provider-related incentives and programs that promote integration with the CMS Health Technology Ecosystem. Additionally, to overcome vast travel distances, Nevada will prioritize technology solutions that are sustainable, rapidly scalable, and operationally efficient in low-bandwidth environments.

Aside from specific initiatives for workforce development, Nevada's RHT funding will be made available for discreet projects, entities, and/or vendors through multiple state competitive procurement processes, compliant with 2 CFR 200.317–327 and state law, for proposals that include measurable performance milestones, indicators and deliverables in addition to clear regular reporting and monitoring requirements for accountability purposes. The state intends to score certain proposals higher if they foster or bolster regional **partnerships** across hospitals or specific health provider systems that

will increase access to quality and affordable care in rural Nevada. A critical factor for receipt of funds through these competitive state procurements and awards will be the applicant's demonstration of the program's **long-term sustainability**. To avoid fiscal cliffs for providers and the state budget, long-term sustainability plans must not include a significant reliance on new state funding proposals that have not yet been approved by the state legislature. The terms and conditions of the federal RHT award will flow down to all subawards and contracts, including cost limitations, and will be consistent with the requirements specified in the NOFO and the state's application.

Additionally, Nevada recognizes the transformation of the state's rural healthcare system depends heavily on the financial stability of small standalone hospitals and clinics that currently operate on negative or narrow operating margins. The vulnerability of these hospitals is driven by a complex interplay of financial, demographic, and systemic challenges. To address these issues, Nevada has a fiscal-sustainability and **financial solvency strategy** for rural providers that: (1) integrates value-based payment reform into the delivery system (see Initiative #1); (2) applies strategies for facility right-sizing (see Initiative #2); and (3) promotes revenue diversification (see Initiative #2) to ensure operational solvency beyond FFY 2031.

More details on Nevada's **cause identification** findings and its strategies and initiatives to address this issue are described in the table below:

Cause	Description	Initiatives/Strategies
Low patient volume and high-fixed costs	Low population density in NV's rural and frontier areas results in low patient volume. However, hospitals must maintain essential, high-fixed-cost services (such as 24/7 emergency care, trauma preparedness, and minimum staffing) regardless	See Initiatives #1 and #2.

	of patient volume, leading to modest budgets and negative operating margins.	
Adverse payer mix	Rural and frontier populations often have lower incomes, higher poverty rates, and are more likely to be covered by Medicare and Medicaid or to be uninsured. Since federal and state payers often provide lower reimbursement rates than commercial payers, and uncompensated care (including charity care and bad debt) is higher, the payer mix heavily strains hospital finances.	See Initiatives #1 and #2.
Workforce recruitment & retention	The remote geographic location makes it difficult to recruit and retain clinical staff, particularly specialists, as rural and frontier areas often have lower salaries, limited professional opportunities, and fewer amenities for families. Workforce shortages drive up costs for temporary staff and limit the ability to provide essential services, such as obstetrics or behavioral health.	See Initiative #3
Resident bypass of rural provider system	Many rural and frontier patients, particularly those with higher-acuity needs or private insurance, may bypass their local hospital for perceived higher quality or specialized care in urban centers (e.g., Las Vegas or Reno), further contributing to low volume and financial stress for the local facility.	See Initiatives 2, 3 & 4
Capital and technology constraints	Lean operating budgets make it difficult to invest in necessary capital improvements, modern equipment, and advanced health IT systems (including robust cybersecurity), leaving facilities vulnerable and making it harder to meet current quality and reporting standards.	See Initiative 4

Most strategies and initiatives in the state's application do not require state **legislative or regulatory action** prior to implementation. However, for those that do, the state has provided more information below in the State Policy Action sections for each initiative. To receive and expend newly awarded RHT grant funds in January of 2026 prior to the next full legislative convening in 2027, the Nevada Health Authority must seek approval from the state's Interim Finance Committee which is a subgroup of the full state legislature.

To expedite this process and avoid delays in processing new RHT funds in January of 2026, the Nevada Health Authority will seek approval at the next regularly scheduled

meeting for this legislative subgroup in December of 2025. This process is consistent with the state's acceptance of other federally awarded grant funds. Because of the stakeholder engagement conducted over the last 2-to-3 months, the Nevada Health Authority does not anticipate barriers with such state approval**.**

By the end of Fiscal Year 2031, Nevada will use these funds to achieve the following RHT program key performance objectives:

A. Goal 1: Make rural Nevada healthy again

Performance Objective: Increased access rates for preventive and primary care.

1. **Target:** Improve rural performance on core HEDIS metrics for basic health screenings and other preventive services for children and adults in rural areas by FY 2031. **Baseline:** 2025 HEDIS scores for Adult Access to Preventive/Ambulatory Health Services (AAP) and Child and Adolescent Well-Care Visits (WCV). The Nevada Health Authority will use vendor support for calculating baselines from claims data through Nevada's All-Payers Claims Database.

B. Goal 2: Strengthen Nevada's rural health systems

Performance Objective: Improved financial sustainability of rural hospitals and clinics.

1. **Target:** No new closures of rural hospitals (CAHs) due to financial challenges after major changes from H.R. 1 go into effect in FY 2028 until FY 2031. **Baseline:** Number of CAHs in 2028 serving rural areas.

C. Goal 3: More rural Nevada network providers

Performance Objective: Increase the number of providers serving rural Nevadans.

1. **Target:** Increase the number of primary care physicians in rural and frontier counties by at least 25 percent by FY 2031. **Baseline:** As of 2024, average number of primary care physicians in rural and frontier counties is 60.1 per 100,000 population.

2. **Target:** Increase the number of advanced nurse practitioners in rural and frontier by at least 25 percent. **Baseline:** As of 2024, the average number of APNs in rural and frontier counties is 49.1 per 100,000 population.

3. **Target:** Increase the number of physician assistants in rural and frontier counties by at least 25 percent by FY 2031. **Baseline:** As of 2024, the number of PAs in rural and frontier counties is 26.9 per 100,000 population.

4. **Target:** Increase the number of registered nurses in rural and frontier counties by at least 25 percent by FY 2031. **Baseline:** As of 2024, the average for rural and frontier counties is 603.3 RNs per 100,000 population.

D. Goal 4: Fill gaps with innovative tech solutions

Performance Objective: Increase access to virtual or hybrid care solutions for rural Nevadans.

1. **Target:** Increase the number of claims paid by Nevada Medicaid for telehealth services provided to rural enrollees by at least 25 percent by FY 2031.

   Baseline: Using claims data, the Nevada Health Authority will establish the current number of claims paid by Nevada Medicaid for telehealth services provided to rural enrollees in FY 2025.

To guide this important work, Nevada will form a **Rural Health Transformation Steering Committee (RHTSC)** with members appointed by the Director of the NVHA with approval

from the Governor of Nevada. This group will track progress on all RHT initiatives and recommend adjustments to ensure the RHT Plan maintains alignment with federal goals and delivers lasting, transformational impact for rural healthcare in Nevada. The RHTSC will be composed of a broad array of representatives from rural health systems and communities in addition to state, local, and tribal health representatives as illustrated in the table below.

Table 3: RHTSC Membership

RHTSC Membership
1. Director or his or her designee of the Nevada Health Authority
2. Director or his or her designee of the Governor's Office of Economic Development
3. Administrator or his or her designee of the Division of Public and Behavioral Health, Nevada Department of Human Services
4. Representative from the Nevada Tribal Health Authority
5. Representative from the Nevada Rural Hospital Partners
6. Representative from the Nevada Primary Care Association
7. Representative from the Nevada State Office of Rural Health (SORH)
8. Representative from the Nevada Higher System of Education (NSHE)
9. Representative from Great Basin College (GBC)
10. Rural or frontier county official from the Nevada Association of Counties
11. A frontier county consumer representative
12. A rural county consumer representative
13. Representative from a rural Certified Community Behavioral Health Center
14. Representative from a rural emergency medical services (EMS) provider
15. Representative with expertise in population health management

The membership reinforces federal expectations for a cross-sector governance structure for the RHT Program and addresses public input that identified priorities for community representation and behavioral health integration. Members will be selected through a transparent application process administered by the Nevada Health Authority. The Nevada Health Authority will convene the Committee quarterly so members can review progress, evaluate performance data, and recommend any mid-course adjustments to ensure alignment with statutory benchmarks.

Below is Nevada's current policy, any legislative or regulatory actions the state is committed to pursuing, proposed timeline for pursuing, and how the specific legislative or regulatory action will improve access, quality, or cost of care in rural communities – for each State policy related to the state policy actions and technical score factors (see also response to factors A.2. in RHTP CCBHC Data Submission Template attached within the Other Supporting Documents section of the state's application). Regarding factor A.7., the state confirms that 10 hospitals received DSH payments in SFY25.

Technical Factor	State Policy Action
B.2. Health and lifestyle	Nevada does not currently require schools to reestablish the Presidential Fitness Test, however the state is interested in progressing toward reinstating the Presidential Fitness Test regulation in a way that is aligned with any announced federal guidance associated with Executive Order 14327, with the following proposed timeline: • March 2026: NVHA to connect with all Nevada school Superintendents to discuss any challenges or barriers school districts may encounter in implementing this requirement, and brainstorm solutions to mitigate gaps and overcome barriers; in addition to developing a strategy together to implement this requirement in Nevada before December 31, 2028. • State will provide updates on progress achieved on this technical factor throughout the project period in required reporting to CMS. This proposed regulatory action will improve the cost of care in rural communities by promoting early physical activity among youth, potentially lowering long-term chronic disease rates and easing demand on limited rural health infrastructure.
B.3. SNAP waivers	Nevada has prepared a USDA SNAP Food Restriction Waiver that prohibits the purchase of non-nutritious items and plans to submit this waiver, with Nevada Governor support, to USDA on or before October 31, 2025. This proposed regulatory action will lower healthcare costs in rural communities by decreasing diet-related diseases, easing pressure on limited medical infrastructure, and promoting long-term public health.
B.4. Nutrition Continuing Medical Education	The state does not currently have a requirement for nutrition to be a component of CME, but is interested in progressing toward a policy initiative to enact this requirement and is committed to working with relevant stakeholders to advance this state policy actions factor throughout the project period, with the following proposed timeline: • February 2026: NVHA to connect with Nevada Board of Medical

	Examiners (BOME) and the Nevada System of Higher Education (NSHE) to discuss openness to a nutrition CME requirement for physicians; discuss potential barriers and brainstorm solutions. • March 2026: NVHA to strategize on potential policy bill for 2027 Legislature to require nutrition CME. • April 2026: NVHA to submit policy bill for consideration in the state's 2027 Legislative Session to include a nutrition CME requirement; request effective date of October 1, 2027. The proposed legislative action will improve quality and cost of care in rural communities by equipping providers to prevent and manage chronic diseases more effectively through dietary interventions.
C.3. Certificate of Need	Nevada's total State CON score as defined in the Cicero report converted to a 100-point score = 100.
D.2. Licensure Compacts	For physician score: Nevada is an Interstate Medical Licensure Compact (IMLC) issuing Letters of Qualification (LOQs) & Licenses (see Nevada Senate Bill 251 (2015). For Nursing score: Nevada is not a member state. For EMS score: Nevada is a licensure compact member of the EMS Compact (see Nevada Revised Statute (NRS) 450B.145. For Psychology score: Nevada is a PSYPACT participating state (see NRS 641.227) For Physician Assistant (PA) score: Nevada does not have any active legislation filed to become a PA compact member. Nevada may be interested in progressing toward a policy initiative to join the physician's assistant (PA) compact and is committed to working with relevant stakeholders to advance this state policy actions factor throughout the project period, with the following proposed timeline: • February 2026: NVHA to connect with the Patient Protection Commission and the BOME to discuss openness to the state joining an interstate PA compact; discuss potential barriers and brainstorm solutions. • March 2026: NVHA to strategize on potential policy bill for 2027 Legislature to join an interstate PA compact. • April 2026: NVHA to submit policy bill for consideration in the state's 2027 Legislative Session to include the state joining an interstate PA compact; request effective date of October 1, 2027 The proposed legislative action will improve access to care in rural communities by accelerating workforce deployment, and attracting more providers to underserved areas
D.3. Scope of Practice	For PA score: Nevada scores at "reduced".

	For nurse practitioner (NP) score: Nevada scores at "full practice". For the pharmacist score: Nevada scores at a "3" on the Cicero report For the dental hygienists score: Nevada allows 7 of the 8 types of tasks, scoring at "unrestricted".
E.3. Short-term, limited duration insurance (STLDI)	Nevada does not have any state restrictions in place that limit STLDI plans beyond the latest federal guidance. Nevada's maximum allowable contract term for STLDI is 185 days. Nevada's maximum allowable total coverage period for STLDI is also 185 days.
F.1. Remote care services	Medicaid payment for at least one form of live video: Nevada Medicaid Services Manual (MSM) Chapter 3400 Section 3403.3: Nevada Medicaid reimburses for synchronous telehealth interactions, which are defined as real-time interactions between a recipient located at an originating site and a healthcare provider located at a distant site. A provider has direct visualization of the patient. Medicaid payment for Store and Forward: Nevada MSM Chapter 3400 Section 3403.4: Nevada Medicaid reimburses for asynchronous telehealth services, also known as Store-and-Forward, which are defined as the transmission of a patient's medical information from an originating site to the healthcare provider distant site without the presence of the recipient. Nevada Medicaid reimburses for services delivered via asynchronous telehealth, however, these services are not eligible for originating site facility fees. Medicaid payment for Remote Patient Monitoring (RPM): Nevada Medicaid does not currently reimburse for RPM. In-State licensing exception: Nevada Medicaid does not require an in-state licensure when enrolling individuals and participates in interstate licensure compacts that facilitate licensure across state lines by providing an expedited licensure application process, licensure reciprocity, or mutual license recognition; this exception is in place. Telehealth License/Registration Process (including special licenses): Nevada Medicaid does not have license or registration process to perform services through telehealth.

IV. Proposed Initiatives and Use of Funds

As described in this section, Nevada has several key initiatives that align with the federally permissible uses of RHT funds and the state's strategic goals.

A. Initiative #1: Rural Health Outcomes Accelerator Program

Nevada will establish the Rural Health Outcomes Accelerator Program (RHOAP) that will be used to fund evidence-based initiatives that will improve rural health in key areas of

chronic disease (with an emphasis on preventable cancers, diabetes, CLRD, and heart disease), primary care (emphasis on access and preventative services), behavioral health (emphasis on mental illness, suicide, and substance use among pregnant women and youth), and maternal and infant health (emphasis on prenatal care).

Initiatives may include technology (including but not limited to modern digital health and AI tools, remote patient monitoring, telehealth equipment, and technology for hybrid or remote care models) in support of innovative care models that will expand access to primary care and specialty services in rural communities, including behavioral healthcare services, and collaborative care models that offer rural residents, including children and families, care management services and direct connection to healthcare and community resources. Nevada is interested in investments that promote collaborative care models for connections to diverse resources, community supports, and local/state agencies for families that will help improve health outcomes for children in foster care system or children with serious emotional disorders who live in rural areas.

The RHOAP will also be used to fund financial incentives for rural hospital and provider participation in value-based payment (VBP) arrangements (including Accountable Care Organizations) through a Rural Value Acceleration Network (RVAN), which will aim to align VBPs benefit program to reward providers for improved health outcomes and administrative efficiency. Through the RVANs, Nevada will require participating providers to use a portion of funds awarded to improve their health data sharing and interoperability functions, including requiring such providers to become a CMS Aligned Network provider within 12 to 18 months of participation in the RVAN. Nevada will utilize its contractual

requirements with managed care organizations to build out the long-term financial infrastructure to support value-based payment expansion and sustainability.

Additionally, the RHOAP may be used to fund integrated care models with an emphasis on leveraging a non-traditional healthcare workforce to supplement the rural healthcare system to the extent appropriate under scope of practice laws in Nevada. This could include proposals for formally integrating certified community health workers and peer support specialists into coordinated care teams to serve certain patient populations, as well as expanding the scope and capacity of partnerships with county health departments and FQHCs to deliver behavioral and maternal health services, including prenatal and postpartum care. This increases clinical workforce capacity and improves patient outcomes through coordinated, holistic care.

The RHOAP will be supported through a competitive state procurement process resulting in multiple contract awards; the RHOAP Request for Proposals (RFP) will be revised and updated annually to reflect best practices and lessons learned both within the state and nationally, aimed to continuously improve the RHOAP initiatives in the state, while remaining anchored in sustainability.

Strategic Goal Alignment: This initiative aligns with the federal strategic goal to “Make Rural America Healthy Again.” If Nevada is successful with its awards for these funds, there will be an improvement in health outcomes across rural regions of the state.

Use of Funds: Prevention and chronic disease; behavioral health; appropriate care availability; and innovative care.

Technical Score Factors	Supporting Details
B.1. Population health clinical infrastructure	Through the RHOAP, Nevada will enhance access to preventative care programs, supporting early detection and management of chronic diseases, reducing long-term healthcare costs and addressing the root cause of disease through supporting integrative care teams and chronic disease self-management programs. Nevada's investment in innovative virtual care options will help bridge the geographic and provider access gaps in rural areas through funding telehealth platforms and remote monitoring tools, and training providers in virtual care delivery, etc. The state is building the operational backbone needed for rural hospitals and providers to participate in VBP models, reducing administrative burden by streamlining workflows and compliance with payer requirements, and enhancing financial sustainability for rural providers by shifting from volume-based to outcome-based reimbursement. RHOAP projects will help rural providers adopt more efficient care delivery models, reduce avoidable hospitalizations and emergency visits and improve patient outcomes. Proposals awarded under this initiative are further intended to support rural providers to track and manage population health data more effectively, identify high-risk patients and intervene earlier, and coordinate care across settings. RHOAP doesn't just fund programs, it builds the infrastructure and capacity rural providers need to thrive in value-based payment environment and aligns financial incentives with health outcomes, essential for long-term rural health system transformation in Nevada.
B.2. Health and lifestyle	The RHOAP can play a transformative role in supporting health and lifestyle improvements in rural Nevada by addressing the root causes of poor health and ensuring sustainable, community-centered, evidence-based solutions with clear and measurable outcome improvements by enhancing access to preventative care programs to help people detect and manage chronic conditions early (diabetes, hypertension, etc.), access lifestyle coaching, nutrition counseling, and physical activity programs; expanding access to virtual and in-person care which makes it easier for folks to receive timely care without long travel times, access behavioral health services, and manage chronic conditions with remote monitoring and telehealth check-ins. Targeted initiatives under RHOAP in maternal and infant health can improve prenatal and postnatal care access, support breastfeeding, nutrition and parenting education, and help reduce disparities in birth outcomes and early childhood development. By fostering collaboration across public health, hospitals, providers and academic institutions, RHOAP will build community-based wellness initiatives and support sustainable school and workplace wellness programs. Through the RVAN and investment in vendors to support VBP models, RHOAP rewards providers for helping patients achieve better health outcomes, encourages care models that focus on prevention, education, and lifestyle change, and support the financial solvency of rural health systems that prioritize wellness, ensuring Healthy lifestyles are not only encouraged but supported and sustained by Nevada's healthcare system.
C.1. Rural provider strategic partnerships	RHOAP supported projects, awarded through a state competitive procurement process will prioritize proposals highlighting strategic partnerships, where rural health facilities choose to join clinically integrated care networks with other rural facilities or partner with larger healthcare systems to share resources and improve access to services in their communities in a financially sustainable manner, including those that promote innovative ways to centralize or streamline back-office functions and resources to create cost savings for participants; or that improve financial viability of rural providers, preserve independence of rural providers where appropriate, and strive to keep care local where appropriate. An evaluation committee comprised of appropriate industry and NVHA representatives (mindful of any conflict of interest) will evaluate and score all RHOAP proposals. Additional details will be provided in the official RFP and provided to CMS upon request. All RHOAP projects must demonstrate long-term sustainability. The terms and

Technical Score Factors	Supporting Details
	conditions of the federal RHT award will flow down to all contracts, including cost limitations, and will be consistent with the requirements specified in the NOFO and the state's application.
E.1. Medicaid provider payment incentives	The RHOAP will play a pivotal role in strengthening Medicaid provider payment incentives by funding financial rewards for rural hospitals and providers that participate in VBPs. Through the establishment of the RVAN, RHOAP will help align VBPs across Medicaid, Medicare, commercial payers, and the state's employee benefit program. This alignment ensures that rural providers are incentivized not just for delivering service, but for achieving **measurable improvements** in health outcomes and administrative efficiency. RHOAP proposals addressing VBP must include a clear pathway to two-sided risk arrangements, encouraging providers to share in both the savings and the accountability for costs and outcomes. These proposals must also be grounded in evidence-based models that demonstrate the ability to change both patient and provider behavior, leading to more proactive, coordinated, and cost-effective care.
E.2. Individuals dually eligible for Medicare and Medicaid	The state will consider prioritizing RHOAP competitive RFP proposals that identify and target Nevada's rural dual eligible population to improve duals support and resources. In addition, through the passage of Nevada Senate Bill 207 (2025) the state will implement the first Program of All-Inclusive Care for the Elderly (PACE) by January 1, 2026, in Nevada.

Key Stakeholders: Strong preference for awards will be given to rural CAHs, CCBHCs, clinics, FQCHs, school-based health centers (in addition to schools seeking to offer health services to students) and other rural healthcare providers (including behavioral health and dental providers) seeking to expand or enhance access to rural care. Technology vendors or other external entities, including state, local, or Tribal entities, may be eligible to apply for funds if their application includes a partnership with one or more providers located in rural areas of the state with a clear nexus between the technology or innovative solution and the needs of the rural provider(s) or rural communities impacted by the proposal. Additionally, the state may utilize a portion of these funds to invest in the necessary vendors to implement value-based payment models through the new RVAN that benefit the financial solvency of rural hospitals and providers through more efficient care models and improved population health outcomes.

Outcomes for Initiative 1:

Measurable Outcomes	Baseline Data	Targets
Reduction in death rates from heart disease in rural Nevada	2025 death records.	The trend in death rates from heart disease in rural Nevada plateaus or declines by FY 2031.
Increased prenatal and postpartum care visits by pregnant women in rural Nevada on Medicaid	2025 claims data (Medicaid); HEDIS PPC	HEDIS PPC scores for rural Medicaid enrollees show a statistically significant increase in the number of prenatal and postpartum care visits by FY2030.
Increased care management for treatment of mental health illness and substance use disorder in rural areas	2025 claims data (APCD if available or Medicaid); HEDIS FUM and FUA	HEDIS FUM and FUA scores show a statistically significant increase in the number of rural Nevadans receiving follow up after an emergency visit for mental illness or substance use disorder within 30 days and 7 days.
Reduced age-adjusted rates of suicide in rural Nevada	2025 Nevada Rural & Frontier Health Data Book	The trend in age-adjusted rates of suicide by county in rural Nevada plateaus or declines by FY 2031.

Impacted Counties:

County Name	County FIPS Code	FIPS Class Code
Churchill County	00858638	H1
Douglas County	00858643	H1
Elko County	00857664	H1
Esmeralda County	00858641	H1
Eureka County	00858640	H1
Humboldt County	00863310	H1
Lander County	00863368	H1
Lincoln County	00863992	H1
Lyon County	00858645	H1
Mineral County	00858644	H1
Nye County	00863599	H1
Pershing County	00858646	H1
Storey County	00858642	H1
White Pine County	00858615	H1

Estimated Required Funding: $30 million, annually.

B. Initiative #2: Nevada Rural Health System Flex Fund

Nevada will establish a flex fund to modernize and enhance existing facilities and infrastructure for Nevada's rural healthcare system, including capital and infrastructure expenditures for rural clinics, hospitals, EMS (air and land transport in rural areas), non-emergency medical transportation for rural care, community health programs, mobile care

facilities, medical equipment and supplies, lab and testing technologies, etc. Nevada intends to encourage regional purchasing arrangements for rural facility and infrastructure needs in addition to sharing agreements for transport, mobile units, and medical equipment, as appropriate.

To offset financial volatility in payer mix for rural hospitals and providers, Nevada intends to use a portion of these funds to help expand rural and frontier affiliation networks and shared-services models as encouraged by the NOFO. The goal is for participating providers to gain access to joint purchasing, tele-specialty contracting, and administrative cost-sharing, producing measurable margin improvements. The State will also encourage partnerships with larger health systems under transparent affiliation terms approved by the RHTSC and the Nevada Health Authority.

Nevada also intends to make these funds available for rural hospitals and clinics to purchase the resources, software, and training needed to improve revenue cycle management (RCM). The focus will be on accurate charge capture, coding optimization, and strategic pricing to maximize reimbursement from existing payers, especially in complex areas like cost-based reimbursement for CAHs. Additionally, the state will invest in vendor resources to provide technical assistance to facilitate the transition to and enhancement of REHs where appropriate in the most geographically remote regions of the state in coordination with interested CAHs.

These RHT funds will be available through a state application process for awards, resulting in multiple subawards. Funds must be used to support self-sustaining models for delivery of essential health services and improving the reliability of care for rural

residents, consistent with CMS funding limitations that prohibit new construction or supplanting of existing funds. An evaluation committee comprised of appropriate industry and NVHA representatives (mindful of any conflict of interest) will evaluate and score all Nevada Rural Health System Flex Fund applications. The terms and conditions of the federal RHT award will flow down to all subawards, including cost limitations, and will be consistent with the requirements specified in the NOFO and the state's application.

Strategic Goal Alignment: This initiative aligns with the federal strategic goal for "Sustainable Access." If successful, Nevada will be able to achieve this goal by improving the quality, capacity and sustainability of the state's rural healthcare infrastructure.

Technical Score Factors	Use of Funds: Capital expenditures and infrastructure
C.1. Rural provider strategic partnerships	The Nevada Rural Health System Flex Fund will support rural provider strategic partnerships by prioritizing applications which demonstrate sustainable outcomes, arrangements that include an exchange of best practices and coordination of care, and any arrangements that improve financial viability of rural providers, preserve independence of rural providers where appropriate, and strive to keep care local where appropriate. Additional details will be provided in the official RFA, provided to CMS upon request and in subsequent required reporting, if awarded.
C.2. EMS	The Nevada Rural Health System Flex Fund will support EMS by prioritizing applications which support coordination and innovation between EMS and other provider types, integration with Nevada's healthcare ecosystem; and that include quarterly metrics to NVHA to demonstrate measurable benefits in timely access to emergency services and/or reduction in total cost from emergency care. Additional details will be provided in the official RFA, provided to CMS upon request and in subsequently required reporting, if awarded.
F.1. Remote care services	The Nevada Rural Health System Flex Fund will support remote care services by prioritizing applications which support sustainable access through enhancement of remote care services and infrastructure within Nevada. Additional details will be provided in the official RFA, provided to CMS upon request and in subsequently required reporting, if awarded.

Key Stakeholders: Strong preference for funding awards will be given to rural hospitals and providers (e.g., CAHs, FQHCs, CCBHCs, School-Based Health Centers (and/or

schools for student health services) and primary care and mental health providers) that operate in rural areas. The state may entertain applications for funding awards from other entities if rural provider entities will benefit from the investment and the applicant has memorandum of understanding (MOU) and letters of support with such rural providers (e.g., regional hub and spoke infrastructure costs).

Outcomes:

Measurable Outcomes	Baseline Data	Targets
New regional purchasing and sharing arrangements for rural healthcare infrastructure as a result of RHT grant awards	Number of purchasing and sharing arrangements as of FY 2027, by rural region. (State survey tool)	Increase the number of regional health infrastructure purchasing and sharing arrangements across rural providers each FY after FY 2027.
Increase in transport access for non-emergency and emergency services in rural areas	Claims paid for transport services with respect to non-emergency and emergency services in rural areas (APCD, if available or Medicaid claims data)	Increase in utilization of transportation services for non-emergency and emergency services in rural areas by county by at least 10 percent by FY 2030.
More modern healthcare infrastructure in rural Nevada	Count of purchases of equipment and technology under grant program for infrastructure supports for rural hospitals and providers	Each rural region will have at least one provider or hospital that purchases at least one modern medical equipment or technology product under this grant program, annually.
Increase in the number of mobile care units in rural Nevada	Number of mobile units in rural Nevada as of FY 2026. (State survey tool)	Each rural region will have at least one more active mobile care unit than it did before the RHT Program commenced by FFY 2030.

Impacted Counties:

County Name	County FIPS Code	FIPS Class Code
Churchill County	00858638	H1
Douglas County	00858643	H1
Elko County	00857664	H1
Esmeralda County	00858641	H1
Eureka County	00858640	H1
Humboldt County	00863310	H1
Lander County	00863368	H1
Lincoln County	00863992	H1
Lyon County	00858645	H1
Mineral County	00858644	H1
Nye County	00863599	H1
Pershing County	00858646	H1
Storey County	00858642	H1

County Name	County FIPS Code	FIPS Class Code
White Pine County	00858615	H1

Estimated Required Funding: $40 million, annually.

C. Initiative #3: Workforce Recruitment & Rural Access Program

The state will set up the Workforce Recruitment & Rural Access Program (WRRAP) to attract and retain physicians and other provider types in rural areas of the state with specific retention strategies to ensure WRRAP recipients serve rural areas. Specific strategies the state intends to fund in support of rural health systems include:

- Grow-Your-Own Pipeline Strategy – These include rural high-school-to-career pathways, local training programs, and rural residencies. Programs that recruit and train local students have higher success rates in addressing long-term workforce shortages.
- Tuition & Training Support – Nevada stakeholders support multi-year rural service commitments tied to financial incentives for medical students or other students in a healthcare professional training program. Respondents to the state's public online RHT survey emphasized the need for flexibility in eligibility and targeting high-need specialties (e.g., primary care providers (physicians, physician assistants, and advanced practice nurses), OB/GYN or family practice physicians with special privileges to provide obstetric care and births, licensed nurse midwives, psychiatry, EMS).
- Community Health Workers (CHWs) & Peer Support Specialists (PSSs) – There is strong support in Nevada for scalable, community-based, and cost-effective workforce recruitment and training for CHWs and PSSs as a bridge to connect rural residents with the health system within rural and frontier communities.

- Burnout, Isolation, and Retention – Public survey respondents additionally emphasized the importance of providing housing assistance, peer networks, and behavioral health services to providers to deter burnout, isolation, and improve long-term retention among acute EMS, behavioral health providers, physicians, and maternal care providers. Nevada's retention strategies will focus on continuing education incentives, career-ladder development within CAHs and FQHCs, and apprenticeship networks. Annual retention metrics such as clinician tenure, vacancy reduction, and pipeline participation will remain core performance indicators under the cooperative-agreement evaluation plan. These actions ensure the state's rural and frontier workforce expansion is an enduring investment that strengthens access, quality, and continuity of care statewide.
- Incentives for New Rural Provider Hires – To address short or acute needs for care in rural communities, Nevada intends to deploy funds in Year One to rural hospitals and other health systems or clinics to incentivize new provider hires. The focus of this program will be on high-need provider types for meeting service gaps in rural communities including but not limited to physicians, advanced practice nurses, physician assistants, and other specialists that are often hard to attract to serve in rural communities due to economic and financial barriers. Incentives will include offering financial assistance for housing, relocation and moving costs, signing bonuses, annual stipend for continuing medical education expenses, among other incentives, tied to the 5-year rural service commitment.
- Rural Residency Programs – Over half of physicians stay in the state where they completed their residency.[xxii] Physicians who spend more time in rural residency

training are significantly more likely to choose, and stay in, rural practice.[xxiii] At least half of the rural residency openings funded through the RHT Program must be available to medical school graduates seeking a primary care or family practice residency or specialty fellowships designed to train front-line rural physicians in the areas of pediatrics, geriatrics, maternal or behavioral healthcare (mental health and substance use treatment). This program will be critical for ensuring medical students have an adequate number of physician residency placements in rural communities if they receive tuition payments through the RHT Program with the 5-year rural service commitment requirement.

Strategic Goal Alignment: This initiative aligns with the federal strategic goal for "Workforce Development." If successful, more healthcare providers will be available in rural areas of the state to provide services to residents.

Use of Funds: Workforce

Technical Score Factors:

Technical Score Factors	
B.4. Nutrition Continuing Medical Education	Nevada does not have a requirement for nutrition to be a component of continuing medical education (CME), but is interested in progressing toward a policy initiative to enact this requirement and is committed to working with relevant stakeholders to advance this state policy actions factor throughout the project period, with the following proposed timeline: • February 2026: NVHA to connect with Nevada BOME and NSHE to discuss openness to a nutrition CME requirement for physicians; discuss potential barriers and brainstorm solutions. • March 2026: NVHA to strategize on potential policy bill for 2027 Legislature to require nutrition CME. • April 2026: NVHA to submit policy bill for consideration in the state's 2027 Legislative Session to include a nutrition CME requirement; request effective date of October 1, 2027.
C.1. Rural provider strategic partnerships	WRRAP directly supports strategic partnerships among Nevada's rural providers by strengthening the shared workforce pipeline, enhancing collaborative training infrastructure, and reducing competition for limited clinical talent through: tuition and training assistance with services commitments creates a shared pool of committed providers who agree to serve in rural and frontier areas for at least 5 years, this

Technical Score Factors	
	long-term commitment fosters continuity of care and allows rural providers to plan staffing needs collaboratively, especially in multi-county or regional care networks. Additionally supporting expansion of GME infrastructure by ideally strengthening training consortia among rural hospitals, clinics and academic institutions; these partnerships allow providers the opportunity to share faculty, clinic rotation sites, and educational resources, further building a sustainable rural training ecosystem.
C.2. EMS	Through stakeholder engagement, the state found large public support for multi-year service commitments tied to financial incentives, emphasizing the need for flexibility in eligibility and targeting high need rural specialties, such as EMS. Additionally, stakeholders noted the importance of providing housing support, peer networks, and behavioral health services to providers to deter burnout, isolation, and improve long-term retention among EMS, behavioral health, and maternal care providers. The state fully supports these additions within the WRRAP initiative and plans to prioritize applicants addressing these considerations, in addition to those to improve speed, access, and cost to deliver emergency medical services while addressing long-term financial self-sustainability.
D.1. Talent recruitment	The state is interested in WRRAP applications that support grow-your-own pipelines such as rural high school-to-career pathways, local training programs, and rural residencies. Expanding GME infrastructure to fund the new Rural Physician Residency Program could include partnerships between acute care hospitals/CAHs, FQHCs, and rural clinics (including Tribal Health Clinics) to support rural residency rotations, including providing mobile health services, to develop and sustain a long-standing pipeline of physicians to rural and frontier Nevada. Retention strategies will focus on continuing education incentives, career ladder development within CAHs, rural clinics and FQHCs, and potential mentorship networks coordinated through the NV Health Service Corps. The WRRAP program supports programs including non-physician healthcare providers, non-hospital based providers, and allied health professionals in rural and frontier areas.
D.2. Licensure compacts	Nevada may be interested in progressing toward a policy initiative to join the physician's assistant (PA) compact and is committed to working with relevant stakeholders to advance this state policy actions factor throughout the project period, with the following proposed timeline: • February 2026: NVHA to connect with the Patient Protection Commission and the BOME to discuss openness to the state joining an interstate PA compact; discuss potential barriers and brainstorm solutions. • March 2026: NVHA to strategize on potential policy bill for 2027 Legislature to join an interstate PA compact. • April 2026: NVHA to submit policy bill for consideration in the state's 2027 Legislative Session to include the state joining an interstate PA compact; request effective date of October 1, 2027.
D.3. Scope of practice	Nevada may be interested in progressing toward a policy initiative to increase the physician's assistant (PA) scope of practice and is committed to working with relevant stakeholders to advance this state policy actions factor throughout the project period, proposing in February 2026 to connect with the BOME to discuss openness to increasing the scope of practice for PAs; discuss potential barriers and brainstorm solutions.

Key Stakeholders: Strong preference for awards related to financial incentives and tuition/training assistance programs will be given to rural hospitals and healthcare providers that operate in rural counties (e.g., CAHs, CCBHCs, FQHCs, primary and

behavioral health providers, school health services programs, school-based health centers, and other health-related clinics, etc.). The state may entertain proposals from other entities including academic institutions for funding to support the creation of a Rural Physician Residency Program and for additional tuition and training assistance programs that will secure services in rural communities in Nevada.

Additionally, the state will consider proposals from other non-rural hospitals and healthcare systems that seek to support rural training programs for rural provider systems if such proposals are supported by strong letters of support from local or tribal health officials, rural hospital(s), and other healthcare providers of services located in the communities impacted by the proposal. Local, state and tribal entities may also apply if it aligns with the goals of the WRRAP and there is a clear nexus between the proposal and rural workforce development.

Outcomes:

Measurable Outcomes	Baseline Data	Targets
Number of primary care physicians in rural Nevada	2025 Nevada Rural & Frontier Health Data Book	Increase the number of primary care physicians in rural and frontier counties by at least 25 percent by FY 2031
Number of nurses in rural Nevada	2025 Nevada Rural & Frontier Health Data Book	Increase the number of nurses (RNs and APNs) in rural and frontier by at least 25 percent by FY 2031
Number of physician assistants in rural Nevada	2025 Nevada Rural & Frontier Health Data Book	Increase in the number of physician assistants in rural and frontier by at least 25 percent by FY 2031
Number of behavioral health providers in rural Nevada	2025 Nevada Rural & Frontier Health Data Book	Increase in the number of various behavioral health provider types by at least 15 percent by FY 2031 (e.g., psychologists, clinical professional counselor, youth and family peer supports, licensed clinical social worker)

Impacted Counties:

County Name	County FIPS Code	FIPS Class Code
Churchill County	00858638	H1
Douglas County	00858643	H1
Elko County	00857664	H1

Esmeralda County	00858641	H1
Eureka County	00858640	H1
Humboldt County	00863310	H1
Lander County	00863368	H1
Lincoln County	00863992	H1
Lyon County	00858645	H1
Mineral County	00858644	H1
Nye County	00863599	H1
Pershing County	00858646	H1
Storey County	00858642	H1
White Pine County	00858615	H1

Estimated Required Funding: $80 million, annually.

D. Initiative #4: Rural Health Innovation & Technology (RHIT) Grant

Nevada's rural health transformation strategy relies on real-time, evidence-based decision-making through data connectivity, analytics, and evaluation. Nevada intends to develop the use of interoperable technology, standardized health information sharing, and continuous data reporting to improve clinical quality, population health, and operational performance across all rural and frontier initiatives. The goal is to make it easier for healthcare professionals to work together, access electronic health records, and take part in national health networks, including the CMS Health Technology Ecosystem – while keeping technology flexible and adaptable to local needs.

To support these needs, the state will establish a new rural health innovation and technology grant program to create a more connected and secure system of care for consumers and providers and to improve how providers share and coordinate care in rural areas of the state. These upgrades will help build the necessary infrastructure to expand the use of innovative telehealth services, including remote healthcare in addition to provider mentoring programs to support front-line providers who are caring for providers with complex needs. This can be achieved by funding new tech-enabled hybrid care solutions and remote patient monitoring. All technology and IT systems procured by

the state for RHT funding must include lifecycle management and cybersecurity plans, vendor neutral interoperability guarantees, and sustainability budgets beyond FFY31. Pilot technology that proves cost-effective may transition into Medicaid-covered benefits through State Plan Amendments.

Additionally, a portion of these funds may be used by awardees to fund new consumer facing technology that utilizes mobile-app-based programs focused on prevention of prevalent chronic diseases and unique socioeconomic challenges in rural areas of Nevada. For example, these consumer facing tech tools may be used by awardees to promote healthy lifestyles (including exercise and physical activity), proper nutrition, disease management, and adherence to care plans established by providers, while linking to the patients' clinical care teams virtually.

In alignment with the CMS Health Technology Ecosystem Criteria, app-based conversational AI can provide coaching, reminders, and education with a personalized experience that results in the prevention and management of disease states. For an applicant for an award to receive funding for such AI or other tech-enabled tools, these technologies must comply with clinical and privacy standards and do not provide clinical guidance in addition to HIPAA privacy and security standards. No more than half of the available funds for the RHIT grant can be used annually for these types of consumer-facing AI tools.

Any RHT provider or proposal to receive funds from the state's RHIT grant program must include a plan for how these funds will build out the infrastructure needed for participation in CMS's interoperability framework—CMS Aligned Networks—to upgrade and

modernize the rural healthcare system's technology infrastructure. Examples include upgrades that enable digital health innovation (AI health, remote care and consumer facing tools), real-time population health analytics, maximization of return on investment by reducing IT spend on legacy programs with scalable platforms used by all payers, digital support for value-based payment models, standardization of clinical data exchange across providers and payers to support care coordination, quality reporting, and risk-based contracting with providers.

Use of Funds: IT advances & consumer tech innovation

Technical Score Factors:

Technical Score Factors	
B.1. Population health clinical infrastructure	RHIT offers a powerful mechanism for Nevada to address population health clinical infrastructure and strengthen the rural healthcare ecosystem at the community level by building a more connected system of care. By funding modern digital health and AI tools, RHIT enables providers to seamlessly share data and coordinate care to be able to track outcomes, identify high-risk patients, and intervene earlier. Remote patient monitoring (RPM) technologies allow providers to monitor patients with chronic conditions in real time, reducing hospitalizations and improving self-management. The RHIT is a targeted investment in expanding rural participation in CMS Aligned Networks and will prioritize proposals that fully address this initiative and participation in the CMS Health Technology Ecosystem. An evaluation committee comprised of appropriate industry and NVHA representatives (mindful of any conflict of interest) will evaluate and score all RHIT proposals. Additional details will be provided in the official RFP, provided to CMS upon request and in subsequently required reporting, if awarded.
C.1. Rural provider strategic partnerships	RHIT application priority will also go to those who include an exchange of best practices and coordination of care, partially facilitated through remote care services, and promote regional collaboration among Nevada's healthcare ecosystem.
F.1. Remote care services	RHIT application priority will also go to those who address enhancement of remote care services infrastructure within the state and that include strong sustainability measures.
F.2. Data infrastructure	RHIT applications must align with CMS's Health Technology Ecosystem criteria and ASTP/ONC as applicable; for technologies that have a cloud-based alternative compared to on-premises technology, preference for cloud-based, multi-tenant architecture will be given; investments will be considered only if they have specific measurable rural benefits. RHIT promotes investments in electronic health records (EHRs), clinical support, and operational software infrastructure upgrades that enable participation in data exchange and interoperability.
F.3. Consumer facing technology	RHIT will support the development, appropriate usage and deployment of various consumer-facing health technology tools for the prevention and

	management of chronic disease; supported health technology tools through the RHIT will be aligned with CMS Health Technology Ecosystem criteria for patient-facing apps as applicable. All RHIT applications must include a sustainability plan and features.

Key Stakeholders: Strong preference will be given to applicants that are rural providers or clinics or other entities that have strong letters of support from rural health officials or rural providers that outline how the project would support the goals of the new rural health innovation and technology grant. Local, state, or tribal entities may apply for funds if such funds support the goals of the new grant program for rural health innovation and technology.

Outcomes:

Measurable Outcomes	Baseline Data	Targets
Telehealth service utilization	APCD, if available, or Medicaid claims data for FY 2026	Increase the number of claims paid for telehealth services for rural Nevadans by at least 25 percent by FY 2031.
Rural provider participation in the CMS Health Technology Ecosystem	CMS data on rural health provider participants as of January 1, 2027	Increase in the number of rural providers serving rural Nevadans that participate in the CMS Health Technology Ecosystem by 25 percent by FY 2031.
More cybersecure health data systems in rural Nevada	Count of grants for cybersecurity efforts	For each rural region, at least one hospital or provider clinic will implement new cybersecurity software/technology paid for by the RHT Program by FY 2030.
Use of new AI health tools to support patient care, remote monitoring, enhanced diagnostics, or administrative efficiencies	Count of grants for AI health tools and HEDIS	For each rural region, at least one AI health tool grant will be awarded per FY, starting FY2027. Among populations using these tools will see health outcome improvements depending on the disease state of focus. State will use prevention HEDIS metrics to measure success of individual AI tools funded.

Impacted Counties:

County Name	County FIPS Code	FIPS Class Code
Churchill County	00858638	H1
Douglas County	00858643	H1

County Name	County FIPS Code	FIPS Class Code
Elko County	00857664	H1
Esmeralda County	00858641	H1
Eureka County	00858640	H1
Humboldt County	00863310	H1
Lander County	00863368	H1
Lincoln County	00863992	H1
Lyon County	00858645	H1
Mineral County	00858644	H1
Nye County	00863599	H1
Pershing County	00858646	H1
Storey County	00858642	H1
White Pine County	00858615	H1

Estimated Required Funding: $30 million, annually.

V. Implementation Plan & Timeline

The Nevada Health Authority will serve as the lead agency for the RHT program. The Nevada Health Authority is comprised of the state's Medicaid agency, state-based health insurance exchange, and state employee benefit program in addition to the state's advisory committee for Graduate Medical Education (GME), Patient Protection Commission, health facility licensure and inspections, and the office of analytics (which houses Nevada's new All Payer Claims Database). In the enabling legislation for the Department (SB 494, 2025), the Nevada Health Authority is tasked with developing a plan to transition public health, behavioral health, and maternal health programs to the Nevada Health Authority from the new Department of Human Services in the 2027 Legislative Session.

To implement the new RHT federal grant program, the Nevada Health Authority will hire over a dozen new staff (state and contract employees) in addition to expert vendors to support grant program development and procurement drafting. This team will be led by **an agency manager** (which is a senior level position in Nevada state government), who will serve as the Rural Health Transformation Program Lead (and serve as Project

Director (PD) for the award) and report to the **Deputy Director** of the Nevada Health Authority's community engagement and workforce development activities at the Department who will serve as the interim Project Director until this position is hired. The Deputy Director reports to the **Director** at the Nevada Health Authority who is a member of the Governor's cabinet.

Project management of this new grant program will be led by the agency manager and team with external vendor support in collaboration with the **Rural Health Transformation Steering Committee** as described in Section III of this application. The agency manager will be administering this committee, coordinating with sister agencies, meeting with external stakeholders (public workshops) and hosting other activities each quarter of the program for continued community engagement. The Project Director will work to ensure high-level coordination with the Governor's office, state legislature, CMS, and executive leadership of state and local agencies and universities with respect to the program.

In total the Nevada Health Authority seeks to fund (with RHT funds) 12 full-time state employees and 2 contract employees to implement and manage the new RHT program and initiatives. Eight of these new employees will be responsible for grant management and oversight activities, one employee will be responsible for program evaluation and performance monitoring and reporting, another employee will be responsible for data collection and analytics in addition to dashboard development and management, and the remaining three employees will manage the fiscal services and accounting activities associated with the RHT grant program.

The proposed timeline below for the 5-year grant program applies uniformly across all four of the state's initiatives (except where explicitly stated), ensuring alignment and

consistency throughout each phase, among all activities.

Stage	Timelines/Key Milestones
Stage 0: **Planning phase**	**Q1 CY 2026** • Establish new state fund or account for program (state interim legislative process) • Receive interim legislative approval to accept grants and establish new employee positions • Hire new agency manager to lead RHT implementation and operations • Update website for the new RHT grant program award description and high-level timeline of process **Q2 CY 2026** • Develop any necessary state policies and procedures for grant fund management • Continue hiring of staff for RHT grant management, fiscal services, and contract monitoring • Contract with any necessary vendors through existing master services arrangement or other direct contract services to support development of request for proposals (RFPs) for initiatives • Draft project plan for RHOAP rollout and stakeholder engagement • Establish process for applicants to apply for the RHTSC and appoint members
Stage 1: **Early implementation**	**Q3 CY 2026** • RHOAP project plan finalized and approved by Director at NVHA • Develop any necessary legislative proposals for grant program for the 2027 legislative process (e.g., policy bills for PA state licensure compacts) • Host public workshop to outline the state's RHT programming (high level) and seek feedback on refinement of programs approved by CMS • Host first RHTSC meeting with opportunity for public comment (approve bylaws, review application/program approvals and work plan, and appoint chair and co-chair); gather feedback from committee and public about RFP themes for Year 1 (round 1) and 2 (round 2) proposals/solicitations. • RHT staff/team works with vendors to draft RFPs/RFAs for each initiative, inclusive of requirements for grant oversight and accountability (Round 1 will be limited timeframe to spend due to ramp-up; will prioritize Round 1 RFPs/RFAs) • Draft new policies, requirements, and programs for RHT funding funneled through a non-procurement process (e.g., value-based payment programs) **Q4 CY 2026** • Host RHTSC meeting with opportunity for public comment regarding non-procurement RHT funding programming for feedback prior to initiating activities • Issue competitive RFPs/RFAs for each initiative for Round 1 and 2 no later than December 1, 2026 • Finalize necessary grant-related legislative proposals through Governor's office process

Stage	Timelines/Key Milestones
Stage 2: **Full implementation**	**Q1 CY 2027** • Conduct RFP proposal evaluation and scoring process (confidential) – 30 days after postings and finalize round 1 and 2 awards and contracts with grantees • Begin any necessary state fiscal procedures to begin issuing funds next quarter to awardees • Host RHTSC meeting to announce round 1 and 2 awardees and programs funded with opportunity for public comment; ask several awardees to present high-level overviews of their projected program goals and milestones • Grant oversight and management activities for CY2027 • Legislation introduced to fulfill certain technical factor, state policy actions (as needed) **Q2 CY 2027** • Round 1 and 2 grantee kickoff calls with state team • Round 1 and 2 grantee project plans submitted for state team review/approval • Host RHTSC meeting for updates on progress, early issue identification with grants etc. • Develop public online dashboard of goals/metrics with baseline data for tracking and transparency purposes • Legislation passage for certain technical components (as needed)
Stage 3: **Grant program operations**	**Q3 CY 2027** • Round 1 and 2 grant oversight and management activities • Promotion and communication with media about activities and successes with funds • Host quarterly RHTSC meeting with public comment; discuss topics/programs for Round 3 of RFPs/RFAs for posting depending on CMS grant approvals for year and funding levels • Begin implementation of any legislation passed related to state policy actions • Conduct site visits and audits of current grantees as needed to ensure accountability • RHT staff/team works with vendors to draft RFPs/RFAs for each initiative, inclusive of requirements for grant oversight and accountability – for round 3. **Q4 CY 2027** • Issue Round 3 competitive RFPs/RFAs for each initiative no later than December 1, 2027 • Subrecipient/contractor written annual progress reporting due for Round 1 and 2. • RHT staff/team draft RHT progress report on grant programs per initiative for public posting, CMS, and RHTSC review • Host quarterly RHTSC meeting with public comment • Close out round 1 awarded projects funding. **Q1 CY 2028** • Conduct RFP proposal evaluation and scoring process (confidential) – 30 days after postings and finalize round 3 awards and contracts with awardees • Begin any necessary state fiscal procedures to begin issuing funds next quarter to grantees

Stage	Timelines/Key Milestones
	• Host RHTSC meeting to announce round 3 awardees and programs funded with opportunity for public comment; ask several awardees to present high-level overviews of their projected program goals and milestones • Grant oversight and management activities continued for CY2028 **Q2 CY 2028** • Round 3 grantee kickoff calls with state team • Round 3 grantee project plans submitted for state team review/approval • Host RHTSC meeting for updates on progress, early issue identification with grants etc. • Collect and analyze data from grantees and other sources to continue measuring performance of grantees and impact on overall metrics for program • Update public online dashboard of goals/metrics with baseline data for tracking and transparency purposes **Q3 CY 2028** • Close out round 2 awarded projects funding. • Promotion and communication with media about activities and successes with funds • Host quarterly RHTSC meeting with public comment; discuss topics/programs for Round 4 of RFPs/RFAs for posting depending on CMS grant approvals for year and funding levels • Conduct site visits and audits of current grantees as needed to ensure accountability • Draft performance report summarizing individual grant performance and spending timelines • RHT staff/team works with vendors to draft RFPs/RFAs for each initiative, inclusive of requirements for grant oversight and accountability – for round 4. **Q4 CY 2028** • Issue Round 4 competitive RFPs/RFAs for each initiative no later than December 1, 2028 • Subrecipient/contractor written annual progress reporting due for Round 3. • RHT staff/team draft RHT progress report on grant programs per initiative for public posting, CMS, and RHTSC review • Host RHTSC meeting with public comment; discuss topics/programs for Round 5 of RFPs/RFAs for posting depending on CMS grant approvals for year and funding levels • Host quarterly RHTSC meeting with public comment • Close out round 2 awarded projects funding. **Q1 CY 2029** • Conduct RFP proposal evaluation and scoring process (confidential) – 30 days after postings and finalize round 4 awards and contracts with awardees • Begin any necessary state fiscal procedures to begin issuing funds next quarter to grantees • Host RHTSC meeting to announce round 4 awardees and programs funded with opportunity for public comment; ask several awardees to present high-level overviews of their projected program goals and milestones • Grant oversight and management activities continued for CY2029

Stage	Timelines/Key Milestones
	Q2 CY 2029 • Round 4 grantee kickoff calls with state team • Round 4 grantee project plans submitted for state team review/approval • Host RHTSC meeting for updates on progress, early issue identification with grants etc. **Q3 CY 2029** • Close out round 3 awarded projects funding. • Host quarterly RHTSC meeting with public comment; discuss topics/programs for Round 5 of RFPs/RFAs for posting depending on CMS grant approvals for year and funding levels • Conduct site visits and audits of current grantees as needed to ensure accountability • Draft performance report summarizing individual grant performance and spending timelines • RHT staff/team works with vendors to draft RFPs/RFAs for each initiative, inclusive of requirements for grant oversight and accountability – for round 5. **Q4 CY 2029** • Issue Round 5 competitive RFPs/RFAs for each initiative no later than December 1, 2029 • Subrecipient/contractor written annual progress reporting due for Round 3 and 4. • RHT staff/team draft RHT progress report on grant programs per initiative for public posting, CMS, and RHTSC review • Host RHTSC meeting with public comment • Close out round 3 awarded projects funding. **Q1 CY 2030** • Conduct RFP proposal evaluation and scoring process (confidential) – 30 days after postings and finalize round 5 awards and contracts with awardees • Begin any necessary state fiscal procedures to begin issuing funds next quarter to grantees • Host RHTSC meeting to announce round 5 awardees and programs funded with opportunity for public comment; ask several awardees to present high-level overviews of their projected program goals and milestones • Grant oversight and management activities continued for CY2030 **Q2 CY 2030** • Round 5 grantee kickoff calls with state team • Round 5 grantee project plans submitted for state team review/approval • Host RHTSC meeting for updates on progress, early issue identification with grants etc. • Collect and analyze data from grantees and other sources to continue measuring performance of grantees and impact on overall metrics for program • Update public online dashboard of goals/metrics with baseline data for tracking and transparency purposes

Stage	Timelines/Key Milestones
	Q3 CY 2030 • Close out round 4 awarded projects funding. • Promotion and communication with media about activities and successes with funds • Host quarterly RHTSC meeting with public comment • Conduct site visits and audits of current grantees as needed to ensure accountability • Draft performance report summarizing individual grant performance and spending timelines **Q4 CY 2030** • Subrecipient/contractor written annual progress reporting due for Round 5. • RHT staff/team draft RHT progress report on grant programs per initiative for public posting, CMS, and RHTSC review • Host RHTSC meeting with public comment • Close out round 3 awarded projects funding. **Q1 CY 2031** • Host RHTSC meeting with public comment • Grant oversight and management activities continued for CY2031
Stage 4: **Push for Success Phase**	**Q1 & Q2 CY 2029** • Grant oversight and management activities continued for CY2029 • Collect and analyze data from grantees and other sources to measure performance of grantees and impact on overall metrics for program • Update online dashboard for tracking program success based on overall performance metrics for state's RHT program • Host a grantee summit with multiple stakeholders for the RHT program to energize awardees for the final stretch of the program; promote wins and address and troubleshoot issues with stakeholders and grantees for final push through September 2030 **Q3 & Q4 CY 2029** • Promotion and communication with media about activities and successes with funds • Draft performance report summarizing individual grant performance and spending timelines • Host meetings with grantees as needed to make any adjustments with grantees to programming as needed based on performance report • Conduct site visits and audits of grantees as needed to ensure accountability • Host RHTSC meeting with public comment • Assess spending timelines of awardees to ensure obligated funds will be used within deadlines of grant **Q1 & Q2 CY 2030** • Host RHTSC meeting with public comment • Grant oversight and management activities continued for CY2030

Stage	Timelines/Key Milestones
	• Collect and analyze data from grantees and other sources to summarize performance of grantees and impact on overall metrics for program • Update online dashboard for tracking program success based on overall performance metrics for state's RHT program • Announce successes of program; including media activities and press release **Q3 CY 2030** • Grant closeout activities with state and CMS • Final grantee reporting activities • Final steering committee meeting with report on overall successes and lessons learned from 5-year grant program
Stage 5: **Grant closeout Phase**	**Q2 CY 2031** • Host RHTSC meeting with public comment • Collect and analyze data from grantees and other sources to continue measuring performance of grantees and impact on overall metrics for program **Q3 CY 2031** • Close out round 5 awarded projects funding. • Announce successes of program; including media activities and press release • Conduct site visits and audits of current grantees as needed to ensure accountability • Draft performance report summarizing individual grant performance and spending timelines • Update online dashboard for tracking program success based on overall performance metrics for state's RHT program • Grant closeout activities with state and CMS • Final grantee reporting activities • Final RHTSC meeting with report on overall successes and lessons learned from 5-year grant program

VI. Stakeholder Engagement

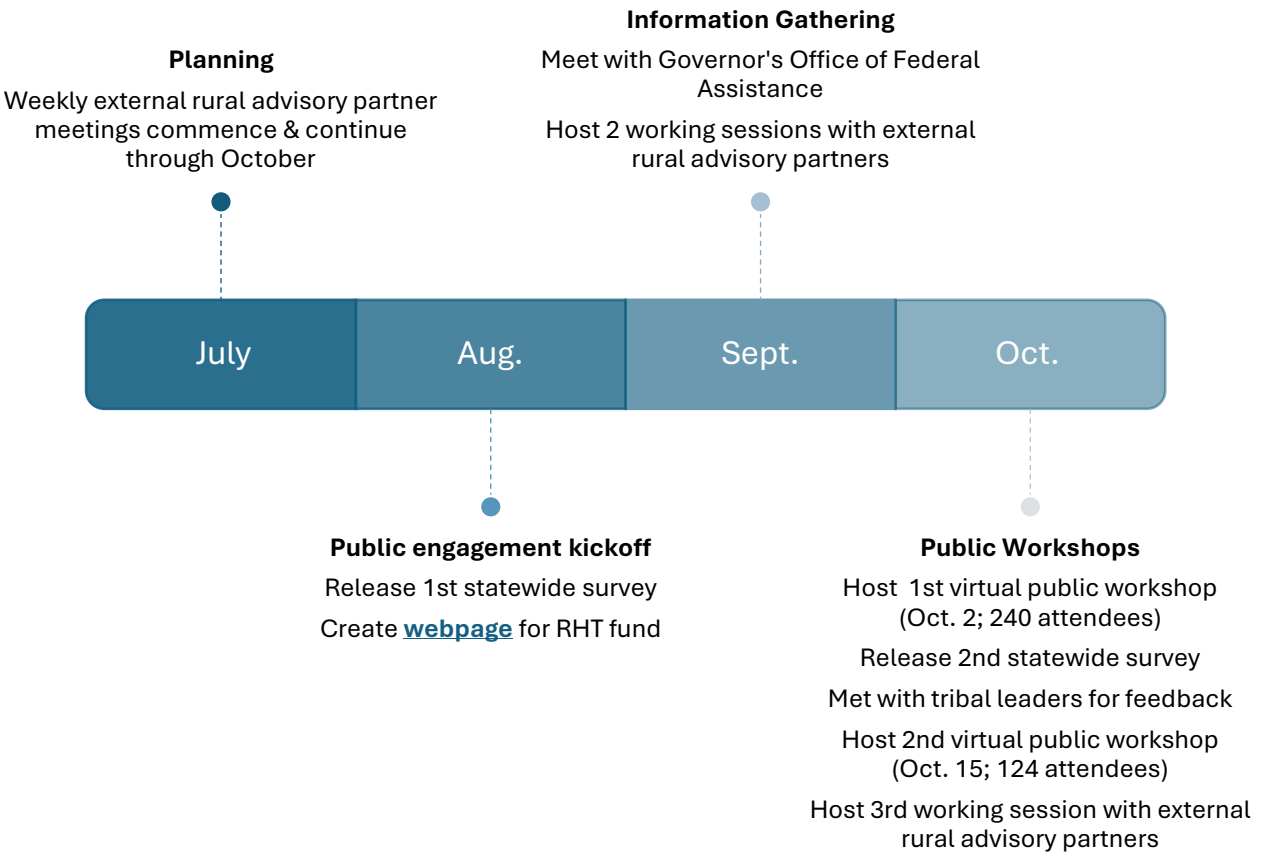
Nevada is thrilled to take part in a new federal grant program aimed at improving rural healthcare. This proposal lays out a clear plan to work hand-in-hand with local communities, Tribal nations, and regional partners to strengthen primary care, chronic disease management, support maternal and child health, and expand behavioral health services.

Thirty days after the release of the notice of funding opportunity, state officials at the Nevada Health Authority leapt into action—requesting ideas and feedback from the public and partners across the state. In this brief time, the state received over 300 public comments, 90 informal proposals, and many requests for meetings with vendors, providers, and others eager to help make a difference in Nevada through this new funding opportunity. The public response was overwhelming; hundreds of Nevadans from dozens of rural health organizations helped shape this proposal. Nevada commits to continuing to bring these voices at the forefront as the program moves forward.

Mindful of the tight timeline, the Nevada Health Authority deployed online statewide surveys to gather broad public input on strategies for funding and hosted two widely attended public workshops in October for targeted feedback on state RHT initiatives. The Nevada Health Authority also met weekly with rural health leaders—which included representatives from the Nevada Rural Hospital Partners, the Nevada Primary Care Association (with a membership that includes FQHCs), the State Office of Rural Health (housed with a state university), and the State Emergency Medical Services (EMS) Office at the Division of Public and Behavioral Health; and met with local and state public health officials on opportunities for bolstering rural health systems and engaged multiple groups upon their request regarding the new federal funding opportunity.

The state also prioritized meeting with Tribal partners at the October Tribal Consultation, and the Tribal Health Clinic Director’s meeting the following day. State staff also engaged the Nevada Department of Veteran’s Services and state and local officials within rural jail and prison systems.

Figure 5: Stakeholder Engagement Activity Prior to Submission of Application



Nevada is committed to funding transparent, accountable, and community-driven approach for the RHT Program by establishing a RHT Steering Committee. The RHTSC will be the primary governance and stakeholder engagement body for Nevada's **stakeholder engagement framework**.

The RHTSC will meet quarterly, with each meeting open to the public and including a dedicated public comment period to provide for public transparency, community input,

and regular stakeholder engagement. Notices for these meetings will be published publicly, and accessible for people virtually and in person to accommodate Nevada's geographically dispersed population.

As shown in Section III, the membership of the RHTSC includes a broad array of stakeholders with both rural and frontier patient representative seats, rural health partner organizations, academia, public health, EMS, Tribal, and county partners—all appointed by the Director of the Nevada Health Authority. Nevada will coordinate regularly with the RHTSC on deploying funds, tracking milestones, and assessing impact metrics. The RHTSC will also include representatives from the state's public health division, state Medicaid agency, state office of rural health, and state tribal health authority.

VII. Metrics & Evaluation Plan

As previously described under each initiative in section IV, the Nevada Health Authority intends to use the following metrics to evaluate performance of the initiatives in meeting the goals for the RHT program. Additionally, the Nevada Health Authority may seek assistance of vendors or academic institutions to bolster its capacity to assess and track data related to performance based on these metrics. Nevada Health Authority commits to cooperating with any CMS-led evaluation and monitoring efforts for the RHT Program.

Initiative #1: Rural Health Outcomes Accelerator program

Goal: Make rural Nevada Healthy Again		Targets
Reduction in death rates from heart disease in rural Nevada	Baseline: 2025 Data Source: State death records, grantee award data, and CDC data Metric: Count of grant awards focused on health outcomes,	FY2028: At least 2 grantees received awards for initiatives aimed at addressing risk factors for heart disease in rural Nevada. FY2029: At least 2 new grantees received awards for initiatives aimed at addressing risk factors for heart

Measurable Outcomes	Baseline Year & Data Source	Targets
	heart disease rates, and death rate trend	disease in rural Nevada. FY2030: The prevalence of heart disease in more than two rural and/or frontier counties is at or lower than it was in FY2025. FY 2031: The trend in death rates from heart disease in rural Nevada has plateaued or declined.
Increased prenatal and postpartum care visits by pregnant women in rural Nevada on Medicaid	Baseline: 2025 Data Source: Grantee award data and State collected claims data (Medicaid MMIS); Metric: HEDIS PPC	FY2028: At least 2 grantees received awards for initiatives aimed at increasing access to and/or utilization of prenatal and postpartum care in one or more rural and/or frontier counties. FY2029: At least 2 new grantees received awards for initiatives aimed at increasing access to and/or utilization of prenatal and postpartum care in one or more rural and/or frontier counties. FY2030: HEDIS PPC scores for rural Medicaid enrollees show improvement in at least two rural or frontier counties. FY2031: HEDIS PPC scores for rural Medicaid enrollees show a statistically significant increase in the number of prenatal and postpartum care visits.
Increased care management for treatment of mental health illness and substance use disorder in rural areas	Baseline: 2025 Date Source: Grantee award data and state claims data (APCD if available or MMIS Medicaid) Metric: HEDIS FUM and FUA	FY 2028: At least 2 grantees received awards for initiatives aimed at improving access to, and/or utilization of mental health and/or substance use treatment in one or more rural and frontier counties. FY 2029: At least 2 new grantees received awards for initiatives aimed at improving access to, and/or utilization of mental health and/or substance use treatment in one or more rural and frontier counties. FY 2030: HEDIS FUM and FUA scores for rural Medicaid enrollees show improvement in at least two rural and/or frontier counties.

Measurable Outcomes	Baseline Year & Data Source	Targets
		By FY2031: HEDIS FUM and FUA scores show a statistically significant increase in the number of rural Nevadans receiving follow up after an emergency visit for mental illness or substance use disorder within 30 days and 7 days.
Reduced age-adjusted rates of suicide in rural Nevada	Baseline: 2025 Data Source: Nevada Rural & Frontier Health Data Book; CDC data Metric: Age-adjusted suicide rates	FY 2028: At least 2 grantees received awards for addressing suicide in rural Nevada. FY 2029: At least 2 new grantees received awards for addressing suicide in rural Nevada. FY 2030: Suicide rate trends in at least two rural and/or frontier counties show a decline. FY: 2031: The trend in age-adjusted rates of suicide by county in rural Nevada plateaus or declines.

Initiative #2: Nevada Rural Health System Flex Fund

Goal: Strengthen rural health systems

Measurable Outcomes	Baseline Year & Data Source	Targets
New regional purchasing and sharing arrangements for rural healthcare infrastructure as a result of RHT grant awards	Baseline: 2026 Data Source: State survey data Metric: Number of purchasing and sharing arrangements as of by rural region. Stratified by region	Increase the number of regional health infrastructure purchasing and sharing arrangements across rural providers each FY after FY 2027.
Increase in transport access for non-emergency and emergency services in rural areas	Baseline: 2025 Data Source: APCD and/or Medicaid MMIS claims data Metric: Utilization rates by service type Stratified by rural region	Increase in utilization of transportation services for non-emergency and emergency services in rural areas by county by at least 10 percent by FY 2030.

Measurable Outcomes	Baseline Year & Data Source	Targets
More modern healthcare infrastructure in rural Nevada	Baseline: 2025 Data Source: Count of successful purchases/invoices for equipment/technology by grantee/rural provider for infrastructure supports Stratified by rural region	Each rural region will have at least one provider or hospital that purchases at least one modern medical equipment or technology product under this grant program, annually.
Increase in the number of mobile care units in rural Nevada	Baseline: 2025 Data Source: NVHA mobile unit licensure data Metric: # of mobile units Stratified by rural region	Each rural region will have at least one more active mobile care unit than it did before the RHT Program commenced by FFY 2030.
More financially sustainable CAHs and FQHCs in rural Nevada	Baseline: 2025 Data Source: NVHA licensure data Metric: # of CAHs & FQHCs Stratified by rural region	No new closures of CAHs and FQHCs in rural Nevada from FY2027 to FY2030

Initiative #3: Workforce Recruitment & Rural Access Program

Goal: More rural network providers

Measurable Outcomes	Baseline Year & Data Source	Targets
Number of primary care physicians in rural Nevada	Baseline: 2025 Data Source: Nevada Rural & Frontier Health Data Book	Increase the number of primary care physicians in rural and frontier counties by at least 25 percent by FY 2031
Number of nurses in rural Nevada	Baseline: 2025 Data Source: Nevada Rural & Frontier Health Data Book Metric: # of primary care physicans	Increase the number of nurses (RNs and APNs) in rural and frontier by at least 25 percent by FY 2031
Number of physician assistants in rural Nevada	Baseline: 2025 Data Source: Nevada Rural & Frontier Health Data Book Metric: # of physician assistants in rural and frontier counties	Increase in the number of physician assistants in rural and frontier by at least 25 percent by FY 2031

Measurable Outcomes	Baseline Year & Data Source	Targets
Number of behavioral health providers in rural Nevada	Baseline: 2025 Data Source: Nevada Rural & Frontier Health Data Book Metric: # of behavioral health providers by provider type (available in the data soure)	Increase in the number of various behavioral health provider types by at least 15 percent by FY 2031 (e.g., psychologists, clinical professional counselor, youth and family peer supports, licensed clinical social worker)

Initiative #4: Rural Health Information & Technology program

Goal: Fill gaps with innovative tech solutions

Measurable Outcomes	Baseline Data	Targets
Telehealth service utilization	Baseline: 2025 Data Source: APCD and/or Medicaid MMIS claims data Metric: Utilization for services delivered through telehealth modalities in rural areas	Increase the number of claims paid for telehealth services for rural Nevadans by at least 25 percent by FY 2031.
Rural provider participation in the CMS Health Technology Ecosystem	Baseline: 2025 Data Source: CMS data on participants and State survey data Metric: # of participants annually	Increase in the number of rural providers serving rural Nevadans that participate in the CMS Health Technology Ecosystem by 25 percent by FY 2031.
More cybersecure health data systems in rural Nevada	Baseline: 2025 Data Source: grant data Metric: # of successful grants for cybersecurity efforts	For each rural region, at least one hospital or provider clinic will implement new cybersecurity software/technology paid for by the RHT Program by FY 2030.
Use of new AI health tools to support patient care, remote monitoring, enhanced diagnostics, or administrative efficiencies	Baseline: 2025 Data Source: State survey tool Metric: # of successful grants for AI health tools	For each rural region, at least one AI health tool grant will be awarded per FY, starting FY2027.

VIII. Sustainability Plan

By design, Nevada's RHT Program will transform a time-limited federal cooperative agreement into a durable, self-sustaining framework for rural health. The State's long-term strategy embeds multiple successful RHT initiatives into permanent state policy, fiscal mechanisms, and public-private partnerships to help ensure continuity of outcomes beyond FFY 2031. When federal funding sunsets, the goal is for Nevada's rural and frontier communities to continue to benefit from expanded sustainable access to care, improved health outcomes, and more financially stable systems supported through existing State appropriations, Medicaid payment structures and coverage, new value based payment models supported by a statewide purchasing and contracting strategy, private or local funding sources, and regional partnership reinvestment models.

Initiative/Program Types	Long-term funding Strategy
Initiative #1: Rural Health Outcomes Accelerator Program (RHOAP) • Value-based payment models • RHOAP grant programs for chronic disease	Managed care contracting requirements for standardization of VBPs used by RHOAP and shared savings arrangements NVHA purchasing strategies to align VBPs with Medicaid/RHOAP and the state's public employee benefits plan and exchange products through the Battle Born State Plan (Nevada's new state-contracted qualified health plans) that leverage the RHOAP VBPs for long-term sustainability Other RHT-grant-funded chronic disease programs including those utilizing technology; grantees must submit a long-term financing strategy to get original award for funds. This could include private or local funds in addition to other state grant programs. If Medicaid reimbursement is available but not yet covered in Nevada, NVHA will seek state and federal approval prior to FY2031 to add such coverage to the state's Medicaid benefit set.
Initiative #2: Rural Health System Flex Fund • Infrastructure • Technology • Capital expenditures	All applicants for flex funds must include a reasonable and reliable plan for how the applicant intends to fund maintenance costs for items purchased in order to be eligible for an award of flex funds. This plan may include funding from private, local or state entities (with proof of commitment or

	attestation from private, local or state entity that such funding will be available for long-term sustainability.)
Initiative #3: Workforce Recruitment & Rural Access (WRRAP) Program • Incentive programs to serve in rural Nevada • Tuition assistance & other provider training supports (including career pathways programs) • Rural Physician Residency Program	The state intends to use future federal; pass-through funding available to Nevada in 2030 from its 1332 waiver of the Affordable Care Act to continue the sustainability of many of the incentive programs and tuition assistance programs. CMS approved a portion of these funds for future uses under its existing 1332 waiver for workforce expansion. The state also intends to work with CMS on how to maximize Medicaid reimbursements to rural providers that host residents and expand access to care while meeting certain quality metrics and outcomes (VBPs) through the new residency program(s) established by the RHT funding.
Initiative #4: Rural Health Innovation & Technology (RHIT) Grant Program • Data/IT ecosystem upgrades • AI tools • Remote/virtual care infrastructure • Other tech-enabled tools for health systems	The state will not award funding to an entity under the RHIT unless the applicant has a reasonable and reliable means for future, long-term funding and maintenance. The state will not award RHIT grants to entities that rely solely on the "potential for" future state legislative approval of new state appropriations to fund ongoing costs for the technology.

To achieve the goal of long-term sustainability, Nevada will require all awardees of RHT funds to have a reasonable and justifiable plan for long-term financial self-sustainability that does not include sole reliance on new state appropriations to avoid major fiscal cliffs for the state budget in FY2031 as a result of the RHT program. If state appropriations already exist for an effective program and these funds will expand and enhance these efforts (not supplant state investments), Nevada intends to support such requests while exploring options with the state legislature in 2029 for ongoing enhancement funds after FY31.

However, the Nevada Health Authority cannot commit the state to future appropriations for RHT programs beyond FY31 solely on the basis that a program received RHT funding award. For this reason, awardees must have a funding plan in their proposals in response to future procurement that does not include a sole reliance on new state appropriations

for long-term sustainability. For one-time funding requests to support infrastructure needs, the Nevada Health Authority will request that there be a plan for how the entity will address maintenance expenses on its own without state assistance.

For state employees hired to implement the RHT program, the state intends to utilize these staff beyond the federal grant period by building out and operationalizing a new state technical assistance center for rural health systems to support continued expansion of value-based payment, revenue maximization, and long-term financial sustainability for the state's rural healthcare system. The Nevada Health Authority will include a request to continue to maintain RHT-funded grant staff with state dollars in addition to any necessary vendor resources to support the rural provider technical assistance center in the Governor's budget request for the 2029 biennial legislative session. This new center will be operationalized by FY2031 at the time of the grant expiration and support the long-term fiscal challenges for rural providers including the private rural hospitals affected by the reduction in the provider tax revenue changes under H.R. 1.

By the end of the RHT Program in FY2031, Nevada believes that rural health systems will have greater fiscal strength than before because of the following achievements under the RHT Program:

- Value-based payment models sustained through state contracts with carriers (Medicaid, exchange, and state employee health plan)
- Improved access to chronic disease prevention and management tools for providers and rural Nevadans results in lower healthcare costs over time and improved performance in value-based payment arrangements (e.g., incentive and shared risk VBPs)

- Increased access to qualified providers (rural residency program and trained workforce) to meet service gaps and reduce workload/burnout of current healthcare providers through new providers living in rural Nevada and remote care (including provider mentorship programs like Project ECHO)
- Modernized infrastructure and upgraded health data systems to reduce costly administrative burdens and remove waste in the system
- Increased access to care through covered telehealth services and remote/hybrid-based care models that can supplement onsite care
- Technical Assistance Center for rural health systems to continue support with remote care models, value-based payment, revenue maximization, and other needs identified by the steering committee (RHSTC) about the ongoing needs of rural health systems to sustain the successes of the RHT Program

Altogether, these initiatives stand to make significant improvements in Nevada's rural healthcare infrastructure. Over the next five years, RHT funding will help rural health systems achieve the modernization and innovation of urban health systems in support of advanced care and treatment for rural residents. This includes new advancements in technology and AI that will transform the way rural Nevadans receive healthcare and achieve healthier living.

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